

ITEMIZED STATEMENT OF CHARGES FOR DRUGS

IC File # _____

Emp. Code # _____

Carrier Code # _____

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

Employer FEIN _____

Employee's Name _____

Employee's Name _____ Telephone Number _____

Address _____

Employer's Address _____ City _____ State _____ Zip _____

City _____ State _____ Zip _____

Insurance Carrier _____

() _____ () _____

Home Telephone _____ Work Telephone _____

Carrier's Address _____ City _____ State _____ Zip _____

Social Security Number _____ Sex ☐ M ☐ F _____ / / _____

() _____ () _____

Date of Birth _____

Carrier's Telephone Number _____ Fax Number _____

DATE	DRUG STORE	CITY	NAME OF DRUG & PRESCRIPTION NO.	PHYSICIAN	AMOUNT
				TOTAL	\$

This is to certify that the drugs listed above were related to my workers' compensation injury. (Receipts must be furnished for carrier's file)

Employee signature_____
Carrier's approval**Reimburse employee**Yes ☐ no ☐**Reimburse drug store**Yes ☐ no ☐

EMPLOYER OR CARRIER/ADMINISTRATOR: DRUGS MAY BE REIMBURSED DIRECTLY TO THE EMPLOYEE OR DRUG STORE. IT IS NOT NECESSARY TO SUBMIT BILLS TO THE COMMISSION FOR APPROVAL. PAY AND RETAIN COPY IN CARRIER'S FILE.

EMPLOYEE: Mail your bill in duplicate promptly to employer and/or insurance carrier